Medicare Preventive Services Education Program

A Series of Satellite Broadcasts

Adult Immunizations

HCFA
Health Care Financing Administration

STEPS TO PROMOTING WELLNESS

Adult Immunizations

Guide to Billing Influenza and Pneumococcal Vaccinations

Medicare
Preventive Services
Satellite Program

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Introduction

Steps to Promoting Wellness: Adult Immunizations

Every year pneumonia and flu take the lives of 40,000 to 70,000 Americans - more than all other vaccine preventable diseases combined. Ninety percent of these deaths are in the Medicare population. The goal of *Steps to Promoting Wellness: Adult Immunizations* is to increase awareness and ultimately the utilization of the influenza (flu) and pneumonia (PPV) immunizations. This initiative supports the Healthy People 2000 goal of immunizing 60% of the high-risk population which includes anyone over the age of 65. Particular emphasis is placed on the minority population within this age group.

The following information identifies multiple opportunities for improvement through increased pneumococcal and influenza vaccination of Medicare's most vulnerable and underserved population:

- Nationally, the 1998 rate of influenza and pneumococcal vaccinations for Caucasian beneficiaries was nearly twice that of African American beneficiaries.

- Beneficiaries aged 85 and older had lower influenza and pneumococcal vaccination rates than beneficiaries aged 75-84

- Substantial geographic variation rates exist, with southern states exhibiting some of the lowest rates.

- More than 70% of all pneumococcal vaccinations occurred during October, November, and December; nearly 38% were administered during the month of October alone. For the influenza vaccine, 70% were given during the month of October.

Mass Immunizers

Mass Immunizer Enrollment Process

Note: This enrollment process currently applies only to entities that will (1) bill a carrier; (2) use roster bills; and (3) bill only for influenza and/or PPV vaccinations.

Providers and suppliers must enroll in Medicare even if mass immunizations are the only service they will provide to Medicare beneficiaries. They can enroll by filling out the HCFA-855, the Provider/Supplier Enrollment application. Providers and suppliers who wish to roster bill for mass immunizations should contact the Medicare contractor servicing their area for a copy of the enrollment application and special instructions for mass immunizers that will roster bill. Providers and suppliers who will not provide other covered services to Medicare beneficiaries complete only the portion of the enrollment form that applies to mass immunizers.

Providers/suppliers who wish to bill for other Part B services must enroll as a regular provider or supplier by completing the entire HCFA-855.
Although HCFA wants to make it as easy as possible for providers and suppliers to immunize Medicare beneficiaries and bill Medicare, it must ensure that those providers who wish to enroll in the Medicare program are qualified providers, receive a provider number, and receive the proper payment.

Points of Special Interest to Mass Immunizers

As used by HCFA, the term "mass immunizer" is defined in the following manner: A mass immunizer generally offers influenza vaccinations to a large number of individuals (the general public or members of a specific group, such as residents of a retirement community). Often the influenza or PPV shots are offered during an immunization program or clinic.

A mass immunizer may be a traditional Medicare provider or supplier (such as a hospital outpatient department) or may be a nontraditional provider or supplier (such as a senior citizen's center or a public health clinic).

- A mass immunizer submits claims for immunizations on *roster bills*.

- Mass immunizers *must* accept assignment.

Non-governmental entities (providers, physicians, or suppliers) that provide immunizations free of charge to all patients, regardless of their ability to pay, must provide the benefit free of charge to Medicare beneficiaries and may not bill Medicare. (See Medicare Carriers Manual, Part 3, §§2306.)

However, a non-governmental entity that does not charge patients who are unable to pay or reduces its charge for patients of limited means (sliding fee scale) but does expect to be paid if a

patient has health insurance which covers the items or services provided, may bill Medicare and receive Medicare program payment.

State and local government entities (such as public health clinics) may bill Medicare for immunizations given to beneficiaries even if they provide immunizations free to all patients, regardless of their ability to pay.

Since the influenza and PPV benefits do not require any beneficiary coinsurance or deductible, a Medicare beneficiary has a right to receive this benefit without incurring any out-of-pocket expense. In addition, the administrating entity is required by law to submit a claim to Medicare on behalf of the beneficiary.

The entity may bill Medicare for the amount which is not subsidized from its budget. For example, an entity that incurs a cost of $7.50 per influenza shot and pays $2.50 of the cost from its budget may bill the carrier the $5.00 cost which is not paid out of its budget.

Sometimes an entity receives donated influenza or PPV vaccine, or receives donated services for the administration of the vaccine. In these cases, the provider may bill Medicare for the portion of the vaccination that was not donated.

Completing the Medicare Provider Application

The Medicare General Enrollment Provider/Supplier Application (HCFA-855) must be completed to obtain a Medicare provider number, however for mass immunizations only, completion of the entire form is not required.

A health care provider who wishes to bill Medicare solely for mass immunizations must complete the general application questions and the following sections:

- Section 1A and 1B, enter "Roster" under primary specialty if an individual or enter "Roster" under type of facility in Section 1B if an organization.
- Section 1D, complete the appropriate blocks.
- Section 2, complete and attach notarized or "certified true" copies of the appropriate license, certification, or registration information.
- Section 5, complete the appropriate blocks.
- Section 6, complete the appropriate blocks, enter "n/a" if not applicable. It is not necessary to include the location of every immunization clinic when held around the community in public buildings. However, if establishing a dedicated full-time facility for immunizations, this section must be completed for each facility.
- Section 7, complete the appropriate blocks, enter "n/a" if not applicable.
- Section 8, complete the appropriate blocks, enter "n/a" if not applicable, attach a copy of IRS form CP 575 to verify the employer identification number (EIN).
- Section 9, complete the appropriate blocks, enter "n/a" if not applicable.
- Section 12, complete the appropriate blocks, enter "n/a" if not applicable.
- Section 13, complete the appropriate blocks, enter "n/a" if not applicable.
- Section 14, complete the appropriate blocks, enter "n/a" if not applicable.

- Section 15, complete the appropriate blocks, enter "n/a" if not applicable.
- Section 17 must be completed.
- Section 18, must be completed.

The HCFA-855 application form contains several pages of instructions that provide details about each section that is helpful. Contact your local Medicare contractor's Provider Customer Service department with additional questions or to request forms.

Ensure the most current HCFA-855 application form is used and that appropriate supporting documents are included with the application. Mail the completed form to the Medicare Registration department at your local Medicare contractor.

Roster Billing

Billing Using Simplified Billing Procedures

Individuals and entities submitting claims for PPV and influenza vaccinations must submit a separate preprinted HCFA-1450 or HCFA-1500 for each type of vaccination. Each HCFA-1450 or HCFA-1500 must have an attached roster bill listing the beneficiaries who received that type of vaccination. Each roster bill must also contain all other information required on a roster bill.

Roster bills used for flu and PPV are *NOT* identical:
For services rendered prior to July 1, 2000, a standing order is required for PPV.

Effective for services rendered on or after July 1, 2000, Medicare does not require for coverage purposes that the PPV vaccine be ordered by a doctor of medicine or osteopathy. Therefore, the beneficiary may receive the PPV vaccine upon request without a physician's order and without physician supervision.

An initial PPV vaccine may be administered only to persons at high risk (see below) of pneumococcal disease. Revaccination may be administered only to persons at highest risk of serious pneumococcal infection and those likely to have a rapid decline in pneumococcal antibody levels, provided that at least 5 years have passed since receipt of a previous dose of pneumococcal vaccine.

Persons at high risk for whom an initial PPV vaccine may be administered include all people age 65 and older; immunocompetent adults who are at increased risk of pneumococcal disease or its complications because of chronic illness (e.g., cardiovascular disease, pulmonary disease, diabetes mellitus, alcoholism, cirrhosis, or cerebrospinal fluid leaks); and individuals with compromised immune systems (e.g., splenic dysfunction or anatomic asplenia, Hodgkin's disease, lymphoma, multiple myeloma, chronic renal failure, HIV infection, nephrotic syndrome, sickle cell disease, or organ transplantation).

Persons at highest risk and those most likely to have rapid declines in antibody levels are those for whom revaccination may be appropriate. This group includes persons with functional or anatomic asplenia (e.g., sickle cell disease, splenectomy), HIV infection, leukemia, lymphoma, Hodgkin's disease, multiple myeloma, generalized malignancy, chronic renal failure, nephrotic syndrome, or other conditions associated with immunosuppression such as organ or bone marrow transplantation, and those receiving immunosuppressive chemotherapy. Routine revaccination of people age 65 or older who are not at highest risk is not appropriate.

Those administering the PPV vaccine should not require the patient to present an immunization record prior to administering the pneumococcal vaccine, nor should they feel compelled to review the patient's complete medical record if it is not available. Instead, provided that the patient is competent, it is acceptable for them to rely on the patient's verbal history to determine prior vaccination status. If the patient is uncertain about their vaccination history in the past 5 years, the vaccine should be given. However, if the patient is certain he/she was vaccinated in the last 5 years, the vaccine should not be given. If the patient is certain that the vaccine was given and that more than 5 years have passed since receipt of the previous dose, revaccination is not appropriate unless the patient is at highest risk.

Generally, FOR PART A CLAIMS ONLY, five beneficiaries per day must be vaccinated in order to roster bill. However, this requirement is waived for inpatient hospitals that mass immunize and utilize the roster billing method.

Effective July 1, 1998, FOR PART B CLAIMS ONLY, immunization of at least five beneficiaries on the same date is no longer required for any individual or entity to qualify for roster billing. However, the rosters should not be used for single patient bills and the date of service for each vaccination administered must be entered.

The following blocks can be preprinted on a HCFA-1500 for providers using roster billing for influenza virus vaccine, PPV and/or administration claims: Block 1 (Medicare); Block 2; (See the attached Roster Form at the end of this document); Block 11 (None); Block 20 (No); Block 21 (VO4.8); Block 24B (*Use appropriate POS code)*; Block 24D [*90657, 90658, 90659, 90732, 90669,* G0008 and G0009 (separate line items for each)]; Block 26 (Yes); and Block 29 (0).

For services rendered prior to July 1, 2000, a Unique Provider Identification Number (UPIN) is required on the HCFA-1500 for PPV claims. Because a standing order is required, the UPIN of the physician who wrote the standing order should be placed in block 17A of the HCFA-1500.

Effective for claims with dates of service on or after July 1, 2000, no UPIN is required in Item 17A of the HCFA-1500 for PPV claims since Medicare will no longer require that the vaccine be administered under a physician's order or supervision.

In block 24F of the modified HCFA-1500, providers should show the *unit cost*, not the total for all patients, since contractors will have to replicate the claim for each beneficiary listed on the roster.

Item 32 (Name and Address of Facility): Effective for claims with dates of service on or after July 1, 2000, this item must be completed.

A PHC-affiliated mobile unit should use POS code "71" unless vaccinations are administered in a mass immunization setting. ALL entities that administer vaccinations in a mass immunization setting should use POS code "60" (Mass Immunization Center), no matter the setting. A mobile unit not affiliated with a PHC and not acting as a mass immunization setting should use "99" (other).

The following information should be included on a patient roster form that will be attached to a pre-printed HCFA-1500 under the simplified roster billing procedure: Patient Name and Address; Health Insurance Claim Number; Date of Birth; Sex; Date of Service; Signature or stamped "Signature on File"; and Provider's Name and Identification Number.

The format of the beneficiary roster can be modified to meet the needs of individual providers. It is the responsibility of the carrier to develop suitable roster formats that meet provider and carrier needs and contain the minimum data necessary to satisfy claims processing requirements for these claims.

A signature on file stamp or notation qualifies as a signature on a roster claim form in cases where the provider has access to a signature on file in the beneficiary's record (e.g., when the vaccine is administered in a physician's office).

Inpatient/outpatient departments of hospitals and outpatient departments of other providers may use a signature on file stamp or notation if they have access to a signature on file in the beneficiary's record.

Other services should not be listed along with the influenza vaccine or PPV and administration on the modified HCFA-1500. Other covered services are subject to more comprehensive data requirements which the roster billing process is not designed to accommodate. Other services should be billed using normal Part B claims filing procedures and forms.

In some instances, two entities, such as a grocery store and a pharmacy, jointly sponsor an influenza or PPV vaccination clinic. Assuming that a charge is made for both the vaccine and its administration, the entity which furnishes the vaccine and the entity which administers the vaccine are each required to submit claims. Both parties must file separately for the specific component furnished for which a charge was made.

When billing only for the administration, billers should indicate in block 24 of the HCFA-1500 that they did not furnish the vaccine. For roster billed claims, this can be accomplished by lining through the preprinted item 24 line item component that was not furnished by the billing entity or individual.

The roster billing criteria will not be changed to include mass immunizers that do not accept assignment. The decision to permit mass immunizers to roster bill was made to ensure that the beneficiaries would receive influenza vaccinations and PPV shots but would not incur out-of-pocket expenses.

Medicare's Coverage and Reimbursement

Coverage Policy

For the purpose of the influenza or PPV benefit, any individual or entity meeting state licensure requirements may qualify to have payment made for furnishing and administering the influenza vaccine or PPV to Medicare beneficiaries enrolled under Part B, as long as certain Medicare requirements are met.

Medicare does not require a physician to be present. However, the law in individual states may require a physician's presence. Also, individual state law may require a physician order or other physician involvement.

For services rendered before July 1, 2000, unless PPV is administered under the supervision of a physician, Medicare requires either (1) a prescription written specifically for the beneficiary who is receiving PPV; or (2) a previously written physician order, also known as a standing order. (A standing order is a prescription written in advance by a responsible, identifiable physician to cover certain common treatment situations.) The standing order must specify that the individual or entity providing PPV must:

1. Determine the person's age, health, and vaccination status;

2. Obtain a signed consent;

3. Administer an initial dose of PPV only to persons at *high risk* of pneumococcal disease, *this group includes all individuals aged 65 or over; immunocompetent adults at increased risk of pneumococcal disease or its complications because of chronic illness (e.g., cardiovascular disease, pulmonary disease, diabetes mellitus, alcoholism, cirrhosis, or cerebrospinal fluid leaks); and individuals with compromised immune systems (e.g., splenic dysfunction or anatomic asplenia, Hodgkin's disease, lymphoma, multiple myeloma, chronic renal failure, HIV infection, nephrotic syndrome, sickle cell disease, or organ transplantation*); and

4. Revaccinate only persons at *highest risk* of serious pneumococcal infection, *this group includes persons with functional or anatomic asplenia (e.g., sickle cell disease, splenectomy), congenital immunodeficiency, HIV infection, leukemia, lymphoma, Hodgkin's disease, multiple myeloma, generalized malignancy, chronic renal failure, nephrotic syndrome, or other conditions associated with immunosuppression such as organ or bone marrow transplantation, and those receiving immunosuppressive chemotherapy) and those likely to have a rapid decline in pneumococcal antibody levels, provided that at least 5 years have passed since receipt of a previous dose of PPV*; and

5. Provide a record of vaccination to the patient.

For services rendered on or after July 1, 2000, Medicare does not require for coverage purposes that the vaccine must be ordered by a doctor of medicine or osteopathy. Therefore, the beneficiary may receive the vaccine upon request without a physician's order and without physician supervision.

An initial vaccine may be administered only to persons at high risk of pneumococcal disease. Revaccination may be administered only to persons at highest risk of serious pneumococcal infection and those likely to have a rapid decline in pneumococcal antibody levels, provided that at least 5 years have passed since receipt of a previous dose of pneumococcal vaccine.

A physician may write a standing order for PPV vaccinations that covers an entire group of patients. However, the standing order must specify the items listed in the previous paragraph. For example, a physician who is the director of a clinic may write a standing order that covers all individuals who come into the clinic and request PPV or a hospital physician may write a standing order that covers all hospital inpatients.

It is not necessary for a beneficiary to provide something in writing to show his or her PPV vaccination status, nor is it necessary for the provider to review the beneficiary's medical records. Individuals and entities providing PPV to Medicare beneficiaries may rely on a verbal account of vaccination status provided by a **competent** beneficiary.

Medicare generally pays for one influenza vaccine per season. This may mean that a beneficiary will receive more than one influenza vaccination in a 12-month period. For example, a beneficiary may receive an influenza vaccination in December 1995 for the 1995/96 influenza season and another influenza vaccination in October 1996 for the 1996/1997 influenza season. In this case, Medicare will pay for both shots because the beneficiary received only one influenza shot per season. *Medicare will pay for more than one influenza vaccination per influenza season if it is reasonable and medically necessary.*

High risk individuals need PPV only once in a lifetime. Revaccination of persons 65 and older who are not at highest risk is not appropriate.

If a beneficiary who is not at highest risk is revaccinated because of uncertainty about his or her PPV vaccination status, Medicare will cover the PPV revaccination.

The influenza vaccine, PPV and their administration are a Part B covered service only.

Nontraditional providers and suppliers may bill a carrier for influenza vaccinations or PPV if they meet State licensure requirements to furnish and administer influenza vaccinations. Those individuals and entities that obtain a Medicare provider number and bill Medicare includes but are not limited to: drug stores, senior centers, shopping malls, and self-employed nurses. These providers and suppliers should contact their local contractor to receive a provider number.

A registered nurse employed by a physician may use the physician's provider number if influenza vaccinations or PPV are provided by the nurse in a location other than the physician's office. If the nurse *is not working for the physician* when the services are provided (e.g., a nurse is "moonlighting," administering influenza vaccinations or PPV at a shopping mall at his or her own direction and not that of the physician), the nurse may obtain a provider number and bill

the carrier directly. However, if the nurse *is working for the physician* when the services are provided, the nurse would use the physician's provider number.

The following providers of services may bill intermediaries for the influenza and pneumococcal vaccines:

- Hospitals;
- Skilled Nursing Facilities (SNFs);
- Christian Science Sanitariums (CSSs);
- Rural Primary Care Hospitals (RPCHs);
- Home Health Agencies (HHAs);
- Comprehensive Outpatient Rehabilitation Facilities (CORFs);
- Rural Health Clinics (RHCs);
- Federally Qualified Health Centers (FQHCs);
- Outpatient Physical Therapy (OPT) providers; and
- Independent Renal Dialysis Facilities (RDFs).

Home Health Agencies (HHA): Where the sole purpose for an HHA visit is to administer a vaccine (influenza, PPV, or hepatitis B), Medicare will not pay for a skilled nursing visit by an HHA nurse under the HHA benefit. However, the vaccine and its administration are covered under the vaccine benefit. The administration should include charges only for the supplies being used and the cost of the injection. HHAs are not permitted to charge for travel time or other expenses (e.g., gasoline).

Payment Policy

Medicare pays 100 percent of the Medicare approved charge or the submitted charge, whichever is lower. Neither the $100 annual deductible nor the 20 percent coinsurance apply. Therefore, if a beneficiary receives an influenza vaccination or PPV from a physician, provider, or supplier who agrees to accept assignment (i.e., agrees to accept Medicare payment as payment in full), there is no cost to the beneficiary. If a beneficiary receives an influenza vaccination or PPV from a physician, provider, or supplier who does not accept assignment, the physician may collect his or her usual charge, however may not roster bill for the service.

Participating institutional providers and physicians, providers, and suppliers that accept assignment must bill Medicare if they charge a fee to cover any or all costs related to the provision and/or administration of the influenza vaccine or PPV. They may not collect payment from beneficiaries.

Nonparticipating physicians, providers, and suppliers that do not accept assignment may collect payment from the beneficiary, but they must submit an unassigned claim on the beneficiary's behalf.

The limiting charge provision does not apply to the influenza or PPV benefit. Nonparticipating physicians and suppliers that do not accept assignment for the influenza or PPV benefit may collect their usual charges (i.e., the amount charged a patient who is not a Medicare beneficiary) for influenza vaccine or PPV and its administration. The beneficiary is responsible for

paying the difference between what the physician or supplier charges and the amount Medicare allows. Only items and services paid through the Physician Fee Schedule (and certain other items and services as specified by the Congress) are subject to the statutory limiting charge limits. Influenza vaccine, PPV and their administration are neither paid through the Physician Fee Schedule nor otherwise covered under the limiting charge provision of the law. A change in Medicare law would be required for the influenza vaccine, PPV and their administration to be covered under the limiting charge provision.

The five-percent payment reduction for physicians who do not accept assignment does not apply to the influenza and pnuemococcal benefit. Only items and services covered under limiting charge are subject to the five-percent payment reduction.

State Variances: Medicare's allowed payment amount for influenza vaccine and PPV is determined as it is for any other drug, i.e., Medicare pays the lower of the actual charge or 95% of the median average wholesale price (AWP). Therefore, a provider whose actual charge is the same as 95% of the AWP will receive the 95% of the AWP, and a provider whose actual charge is less than 95% of the AWP will receive the lower payment. The average payment rate for influenza vaccine or PPV for each carrier is the average of all payments for the vaccine made in that carrier's jurisdiction. Therefore, each carrier's average rate varies depending upon how many providers have charged less than the AWP. (The change to 95% of the AWP was effective 01/01/98 per the Balanced Budget Act.)

Medicare payment by carriers for the administration of the influenza vaccine and PPV is linked to payment for services under the physician fee schedule but is not actually paid under the physician fee schedule. The charge for the administration is the lesser of the actual charge or the fee schedule amount for a comparable injection. Since fee schedules are adjusted for each Medicare payment locality, there is a variation in the payment amount nationwide.

Intermediary payment to a provider for the influenza vaccine or PPV and its administration is made on the basis of reasonable cost. The way in which Medicare pays for a given item or service is determined by statute. It would require Congressional legislation for Medicare to pay a nationwide rate.

A physician, provider, or supplier may NOT charge a Medicare beneficiary more for an immunization than he or she charges a non-Medicare patient.

Medicare will pay twice for the administration fee if a beneficiary receives both the influenza vaccine and the pneumococcal vaccine on the same day.

A physician, provider, or supplier may NOT collect payment for an immunization from a beneficiary and instruct the beneficiary to submit the claim to Medicare for payment. Medicare law (§1848 (g)(4) of the Social Security Act) requires that physicians, providers, and suppliers submit a claim for services to Medicare on the beneficiary's behalf.

HCPCS code G0008 (administration of influenza vaccine) and HCPCS code G0009 (administration of pneumococcal vaccine) may be paid in addition to other services, including evaluation and management services and is NOT subject to rebundling charges.

When a physician sees a beneficiary for the sole purpose of administering influenza vaccine or PPV, he or she may NOT routinely bill for an office visit. However, if a patient actually receives other services constituting an "office visit" level of service, the physician may bill for a visit and Medicare will pay for the visit if it is reasonable and medically necessary.

Routine Billing for the Influenza Vaccine and PPV Benefit

HCFA 1450 and HCFA 1500: All data fields that are required for any Part A or B claim are required for the influenza vaccine, PPV and their administration. Providers should bill in accordance with the bill completion instructions in the various provider manuals. Additionally, coding specific to these benefits is required.

The following procedure codes are used for ***influenza vaccine***:

HCPCS Code	Description
90657	Influenza virus vaccine split virus, 6-35 months dosage, for intramuscular use or for jet injection
90658	Influenza virus vaccine, split virus, 3 years and above dosage, for intramuscular use or for jet injection
90659	Influenza virus vaccine, split virus, whole virus, for intramuscular use or for jet injection
G0008	Administration of influenza virus vaccine

The following diagnosis code is used if the sole purpose for the visit is to receive the ***influenza vaccine***:

Diagnosis Code	Description
V04.8	Influenza vaccination

The following procedure codes are used for ***PPV***:

HCPCS Code	Description
90732	Pneumococcal polysaccharide vaccine, 23-valent, adult dosage, for either subcutaneous or intramuscular use
G0009	Administration of pneumococcal vaccine

The following diagnosis code is used if the sole purpose for the visit is to receive ***PPV***:

Diagnosis Code	Description
V03.82	Pneumococcal vaccination

Regardless of where the influenza vaccine or PPV is administered to a dialysis patient of a hospital or hospital-based renal dialysis facility, the hospital bills the intermediary using bill type 13X. Applicable bill types are: 13X, 22X, 23X, 34X, 42X, 52X, 71X (provider-based RHCs only), 72X, 73X (provider-based FQHCs only), 74X, 75X, 83X and 85X.

Independent RHCs are required to use revenue code 521 in order to bill. RHCs follow guidelines in §614 of the RHC/FQHC Manual. They do not include charges for the vaccine or its administration on the HCFA-1450. Payment is made at cost settlement.

Revenue Codes and Therapy Revenue Codes: Providers bill for the vaccine using revenue code 636 and for the administration using revenue code 771. If therapy services are also provided, they can be reflected on the same claim with the vaccine and its administration.

All providers who bill the intermediary for the vaccine report the administration under revenue code 771. This includes inpatient hospital and inpatient skilled nursing facilities.

Bill Types: Medicare hospitals bill for the vaccine under bill type 13X for their inpatients and skilled nursing facilities bill for the vaccine under bill type 22X.

Other charges may be listed on the same bill as influenza vaccine or PPV. However, there must be separate coding for the additional charge(s).

For all influenza vaccination or PPV claims submitted to a carrier, item 11 of the preprinted HCFA-1500 should show "NONE."

With the exception of hospice providers, certified Part A providers must bill their intermediary for this Part B benefit. Hospice providers bill the carrier. Non-Medicare-participating provider facilities bill their local carrier.

HHAs that have a Medicare-certified component and a non-Medicare certified component may elect to furnish the influenza and PPV benefit through the non-certified component and bill the Part B carrier.

There has been some concern about the confusion caused by advertising the influenza vaccination and PPV as "free." When patients later receive Explanation of Medicare Benefits (EOMBs), they contact the carrier to report fraudulent billing. Physicians, providers, and suppliers who accept assignment may advertise that there will be **no charge to the beneficiary**, but *they should make it clear that a claim will be submitted to Medicare on their behalf.*

Physicians, providers, and suppliers who do **not** accept assignment should never advertise the service as free since there will be an out-of-pocket expense for the beneficiary after Medicare has paid at 100 percent of the Medicare-allowed amount.

Managed Care Guidelines

Basic Procedures

HMOs that furnish influenza or PPV vaccinations to non-member Medicare beneficiaries bill the carrier. The carrier will issue a provider number to the HMO. The HMO may use roster billing only if vaccinations are the sole Medicare-covered services furnished by the HMO to non-member Medicare patients.

Beneficiaries enrolled in a risk HMO must receive all of their care through the plan's doctors, hospitals, and other health care providers, except for emergency care and unforeseen out-of-area care. This is referred to as "locked-in."

Beneficiaries enrolled in a cost HMO may choose to receive all of their care through the plan's doctors, hospitals, and other health care providers or may choose to receive their medical care from any other health care provider who participates in the Medicare program. However, if beneficiaries do not choose a plan health care provider, they are responsible for paying all of the coinsurance and deductibles associated with such care.

"Locked-in HMOs": Beneficiaries enrolled in Medicare contracted HMOs generally must obtain the shot through plan providers, or they will have to pay for the shot. HMO enrollees should check with their plan to determine if they are "locked-in" to plan providers for their influenza vaccination or PPV. If not "locked-in," the beneficiary may obtain the vaccination from any qualified provider.

Medicare will not reimburse a non-HMO provider for influenza and PPV vaccinations for beneficiaries enrolled in risk HMOs. Medicare has already paid the HMO to provide this service.

When a beneficiary that belongs to a risk HMO receives an influenza or PPV vaccination from a fee-for-service provider, the beneficiary is responsible for the payment. Carriers should review Quality Assurance (QA) sample influenza virus vaccine and PPV claims billed using the simplified billing process against the instructions provided in the implementing instructions if these claims show up in their QA sample.

Claim Examples

APPROVED OMB NO. 0938-0279

1	2	3 PATIENT CONTROL NO.	4 TYPE OF BILL

5 FED. TAX NO.	6 STATEMENT COVERS PERIOD FROM	THROUGH	7 COV D.	8 N-C D.	9 C-I D.	10 L-R D.	11

12 PATIENT NAME	13 PATIENT ADDRESS
SEE ATTACHED ROSTER	

14 BIRTHDATE	15 SEX	16 MS	ADMISSION 17 DATE	18 HR	19 TYPE	20 SRC	21 D HR	22 STAT	23 MEDICAL RECORD NO.	CONDITION CODES 24	25	26	27	28	29	30	31

	32 OCCURRENCE CODE	DATE	33 OCCURRENCE CODE	DATE	34 OCCURRENCE CODE	DATE	35 OCCURRENCE CODE	DATE	36 OCCURRENCE SPAN CODE	FROM	THROUGH	37
a												A
b												B
												C

38	39 VALUE CODES CODE	AMOUNT	40 VALUE CODES CODE	AMOUNT	41 VALUE CODES CODE	AMOUNT
	a					
	b					
	c					
	d					

	42 REV. CD.	43 DESCRIPTION	44 HCPCS / RATES	45 SERV. DATE	46 SERV. UNITS	47 TOTAL CHARGES	48 NON-COVERED CHARGES	49	
1		DRUG / DETAIL CODE	90732		1	6 60			1
2		ADMINISTRATION	G0009		1	6 60			2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23		TOTAL CHARGES				13 20			23

50 PAYER	51 PROVIDER NO.	52 REL INFO	53 ASG BEN	54 PRIOR PAYMENTS	55 EST. AMOUNT DUE	56
A						
B						
C						

57 **DUE FROM PATIENT ▶**

58 INSURED'S NAME	59 P.REL	60 CERT. - SSN - HIC. - ID NO.	61 GROUP NAME	62 INSURANCE GROUP NO.
A				
B				
C				

63 TREATMENT AUTHORIZATION CODES	64 ESC	65 EMPLOYER NAME	66 EMPLOYER LOCATION
A			
B			
C			

67 PRIN. DIAG. CD.	OTHER DIAG. CODES 68 CODE	69 CODE	70 CODE	71 CODE	72 CODE	73 CODE	74 CODE	75 CODE	76 ADM. DIAG. CD.	77 E-CODE	78
V0382											

79 P.C.	80 PRINCIPAL PROCEDURE CODE	DATE	81 OTHER PROCEDURE CODE	DATE	OTHER PROCEDURE CODE	DATE	82 ATTENDING PHYS. ID
			A		B		a b
	OTHER PROCEDURE CODE	DATE	OTHER PROCEDURE CODE	DATE	OTHER PROCEDURE CODE	DATE	83 OTHER PHYS. ID
	C		D		E		a b
a	84 REMARKS						OTHER PHYS. ID
b							a b
c							85 PROVIDER REPRESENTATIVE 86 DATE
d							X

UB-92 HCFA-1450 OCR/ORIGINAL LCF-UB92

I CERTIFY THE CERTIFICATIONS ON THE REVERSE APPLY TO THIS BILL AND ARE MADE A PART HEREOF.

PLEASE DO NOT STAPLE IN THIS AREA

ROSTER BILLING ONLY

APPROVED OMB-0938-0008

CARRIER

HEALTH INSURANCE CLAIM FORM

PICA ☐☐☐ PICA ☐☐☐

PATIENT AND INSURED INFORMATION

1. MEDICARE ☒ (Medicare #)	MEDICAID ☐ (Medicaid #)	CHAMPUS ☐ (Sponsor's SSN)	CHAMPVA ☐ (VA File #)	GROUP HEALTH PLAN ☐ (SSN or ID)	FECA BLK LUNG ☐ (SSN)	OTHER ☐ (ID)	1a. INSURED'S I.D. NUMBER (FOR PROGRAM IN ITEM 1)
2. PATIENT'S NAME (Last Name, First Name, Middle Initial): SEE ATTACHED ROSTER				3. PATIENT'S BIRTH DATE MM DD YY; SEX M ☐ F ☐			4. INSURED'S NAME (Last Name, First Name, Middle Initial)
5. PATIENT'S ADDRESS (No., Street)				6. PATIENT RELATIONSHIP TO INSURED: Self ☐ Spouse ☐ Child ☐ Other ☐			7. INSURED'S ADDRESS (No., Street)
CITY		STATE		8. PATIENT STATUS: Single ☐ Married ☐ Other ☐			CITY / STATE
ZIP CODE	TELEPHONE (Include Area Code) ( )			Employed ☐ Full-Time Student ☐ Part-Time Student ☐			ZIP CODE / TELEPHONE (INCLUDE AREA CODE) ( )
9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)				10. IS PATIENT'S CONDITION RELATED TO:			11. INSURED'S POLICY GROUP OR FECA NUMBER: NONE
a. OTHER INSURED'S POLICY OR GROUP NUMBER				a. EMPLOYMENT? (CURRENT OR PREVIOUS) ☐ YES ☐ NO			a. INSURED'S DATE OF BIRTH MM DD YY; SEX M ☐ F ☐
b. OTHER INSURED'S DATE OF BIRTH MM DD YY; SEX M ☐ F ☐				b. AUTO ACCIDENT? ☐ YES ☐ NO PLACE (State)			b. EMPLOYER'S NAME OR SCHOOL NAME
c. EMPLOYER'S NAME OR SCHOOL NAME				c. OTHER ACCIDENT? ☐ YES ☐ NO			c. INSURANCE PLAN NAME OR PROGRAM NAME
d. INSURANCE PLAN NAME OR PROGRAM NAME				10d. RESERVED FOR LOCAL USE			d. IS THERE ANOTHER HEALTH BENEFIT PLAN? ☐ YES ☐ NO *If yes*, return to and complete item 9 a-d.

READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.

12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.

SIGNED _____ DATE _____

13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below.

SIGNED _____

PHYSICIAN OR SUPPLIER INFORMATION

14. DATE OF CURRENT: MM DD YY ◀ ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY(LMP)	15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS. GIVE FIRST DATE MM DD YY	16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION MM DD YY FROM / TO MM DD YY
17. NAME OF REFERRING PHYSICIAN OR OTHER SOURCE	17a. I.D. NUMBER OF REFERRING PHYSICIAN	18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES MM DD YY FROM / TO MM DD YY
19. RESERVED FOR LOCAL USE		20. OUTSIDE LAB? ☐ YES ☒ NO $ CHARGES
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY. (RELATE ITEMS 1,2,3 OR 4 TO ITEM 24E BY LINE) 1. V0382 2. ____ 3. ____ 4. ____		22. MEDICAID RESUBMISSION CODE / ORIGINAL REF. NO.
		23. PRIOR AUTHORIZATION NUMBER

24. A DATE(S) OF SERVICE From MM DD YY To MM DD YY	B Place of Service	C Type of Service	D PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS / MODIFIER	E DIAGNOSIS CODE	F $ CHARGES	G DAYS OR UNITS	H EPSDT Family Plan	I EMG	J COB	K RESERVED FOR LOCAL USE
1	60		90732	1						
2	60		G0009	1						
3										
4										
5										
6										

25. FEDERAL TAX I.D. NUMBER SSN EIN	26. PATIENT'S ACCOUNT NO.	27. ACCEPT ASSIGNMENT? (For govt. claims, see back) ☒ YES ☐ NO	28. TOTAL CHARGE $	29. AMOUNT PAID $ 0.00	30. BALANCE DUE $
☐ ☐					

31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.) SIGNED DATE	32. NAME AND ADDRESS OF FACILITY WHERE SERVICES WERE RENDERED (If other than home or office): N/A	33. PHYSICIAN'S, SUPPLIER'S BILLING NAME, ADDRESS, ZIP CODE & PHONE # PIN# GRP#

(APPROVED BY AMA COUNCIL ON MEDICAL SERVICE 8/88) ***PLEASE PRINT OR TYPE*** FORM HCFA-1500 (U2) (12-90) FORM OWCP-1500 FORM RRB-1500

Influenza Virus Vaccine Roster

Provider Payee Name _____

Provider Number _____ Date of Service _____

Number	Insured's I.D. number	Patient's Name (Last, First, Middle Initial)	Patient's Address (Number, street, city, ZIP code)	Patient's date of birth	Patient's sex	Patient's signature, or "signature on file"
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01						
02						
03						
04						
05						
06						
07						
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09						

Pneumococcal Pneumonia Virus Vaccine Roster

Provider Payee Name _____ Date of Service _____

Provider Number _____ Referring Physician's name and UPIN_____

Number	Insured's I.D. number	Patient's Name (Last, First, Middle Initial)	Patient's Address (Number, street, city, ZIP code)	Patient's date of birth	Patient's sex	Patient's signature, or "signature on file"
00						
01						
02						
03						
04						
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WARNING! Ask beneficiaries if they have been vaccinated with PPV

- Rely on patient's memory to determine prior vaccination status
- If patients are uncertain whether they have been vaccinated within the past 5 years, administer the vaccine
- If patients are certain they have been vaccinated within the past 5 years, do not revaccinate